MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10760

CERTIFICATE OF DEATH

Reg. Dist. No. 10760/1287

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b: 3 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kent & Queen Anne's Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): xc Still Pond
d. STREET ADDRESS: ------
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Edward — Middle: Washington — Last: Davis

4. DATE OF DEATH: Month: October — Day: 9 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 9, 1883

9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Payne Davis

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.: 218-20-5126

17. INFORMANT: Lola Davis — Address: Still Pond, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Circulatory collapse — INTERVAL BETWEEN ONSET AND DEATH: 1 day
482x
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) inanition & dehydration — 5 days
DUE TO
(c) intestinal flu & diarrhoea — 2 weeks

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): arteriosclerosis & Coronary heart disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 5, 1957, to Oct 9, 1957, that I last saw the deceased alive on Oct 8, 1957, and that death occurred at 12:55 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Florence Deringer Joyce M.D. — ADDRESS (Street, city or town, state): Worton, Md. — DATE SIGNED: 10/9/57

PHYSICIAN'S NAME (Type): Florence Deringer Joyce

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: 10/12/57

22c. NAME OF CEMETERY OR CREMATORY: Mt. Zion Cemetery

22d. LOCATION (City, town, or county) (State): Still Pond, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Victor N. Kennedy — ADDRESS: Still Pond, Md.

24a. REC'D BY REGISTRAR DATE: 10/10/57

24b. REGISTRAR'S SIGNATURE: E Kennard Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page [illegible] should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10761

CERTIFICATE OF DEATH

Reg. Dist. No. 10761 207

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b: 3 hours
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kent & Queen Anne Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
d. STREET ADDRESS: 210 Mill St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Anthony Middle: DiGiuseppe Last:
4. DATE OF DEATH: Month: IO Day: 2I Year: 19 57

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Mar. 4, I889
9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clothing
10b. KIND OF BUSINESS OR INDUSTRY: Tailor
11. BIRTHPLACE (State or foreign country): Italy
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Enrico DiGiuseppe
14. MOTHER'S MAIDEN NAME: Teresa Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Anthony DiGiuseppe Address: 2IO Mill St. Chestertown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 months
420.1
DUE TO (b): Coronary arterio sclerosis — several years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Patient was convalescing and had a recurrence of the thrombosis, the day of death.

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour: o. m. p. m. Month: Day: Year: 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept. 10, 19 56, to Oct. 21, 19 57, that I last saw the deceased alive on Oct. 21, 19 57, and that death occurred at 9:15A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert W. Farr M.D. ADDRESS (Street, city or town, state): Chestertown, Md. DATE SIGNED: IO/21/I957

PHYSICIAN'S NAME (Type): Robert W. Farr

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: IO/24/57
22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cem.
22d. LOCATION (City, town, or county) (State): Prince George Co. Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: J. Willis Wells ADDRESS: Chestertown, Md.
24a. REC'D BY REGISTRAR DATE: OCT 22 1957
24b. REGISTRAR'S SIGNATURE: Clara Barnes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10762

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10762 Items 11,14, Film C221 10-21-57 et

Reg. Dist. No. 202

1. PLACE OF DEATH
a. COUNTY: Kent
MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Kent

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown

c. LENGTH OF STAY IN 1b: 23 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown 37

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 302 Cannon Street

d. STREET ADDRESS: 302 Cannon Street

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Leola; Middle: Rene; Last: Griffin

4. DATE OF DEATH: Month: October; Day: 14; Year: 1957

5. SEX: Female

6. COLOR OR RACE: col.

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 21, 1957

9. AGE (In years last birthday): yrs.
IF UNDER 1 YEAR: Months; Days: 23
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): ~~Maryland~~ New York City

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James Griffin, Jr.

14. MOTHER'S MAIDEN NAME: Lucille Griffin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: no

17. INFORMANT: Kenneth Walley, Address: Still Pond, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Unknown - probably congenital heart disease
DUE TO (b): Child had eaten well, breathed well, and had seemed perfectly well in every respect since birth.
DUE TO (c): Child ate 4 oz of milk 1:30 A.M. It was put to bed;

754.4

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 8:00A.M. the mother thought the child was asleep and did not try to feed it. It was found dead at 1:30 P.M. Examination of the body did not discover any evident causes of death.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m.; Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Noturol couses ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined couse ☒.

ACTUAL SIGNATURE: Robert W. Farr M.D. Burtable

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Robert W. Farr, M. D.

DATE SIGNED: October 15, 195

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Oct. I5, 1957

22c. NAME OF CEMETERY OR CREMATORY: Janes Cem.

22d. LOCATION (City, town, or county) (State): Chestertown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Kenneth Walley

ADDRESS: Chestertown, Md.

24a. RECD BY REGISTRAR DATE: OCT 17 1957

24b. REGISTRAR'S SIGNATURE: Mary L. Barnes

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please exe[illegible] the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the [illegible] or to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for [illegible] files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the re[illegible] prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10763

10763

CERTIFICATE OF DEATH

Reg. Dist. No. 202

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY: KENT	MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHESTERTOWN	c. LENGTH OF STAY IN 1b: 5 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kent & Queen Anne's Hosp.	
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: N.Y.	b. COUNTY: ORANGE.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CORNWALL 69x-3	
d. STREET ADDRESS: Old West Point Road	e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print): First JAMES Middle E Last HALL	4. DATE OF DEATH: Month OCT. Day 14 Year 1957
5. SEX: M	6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH: JAN 3, 1880
9. AGE (In years last birthday): 77 yrs.	IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED.	10b. KIND OF BUSINESS OR INDUSTRY: FARM OWNER
11. BIRTHPLACE (State or foreign country): New York	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Henry Hall	14. MOTHER'S MAIDEN NAME: Hannah Owens
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: NONE
17. INFORMANT Address: HOSPITAL CHART.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Concussion — INTERVAL BETWEEN ONSET AND DEATH: 5 days.

825x

DUE TO (b): Skull Fracture.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): ARTERIOSCLEROTIC HEART DISEASE

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): AUTOMOBILE CRASH.

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year: Oct 9 1957

20d. INJURY OCCURRED White at work ☐ Not white at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway

20f. (City or town) (County) (State): Queen Anne, Md

21. I certify that I attended the deceased from 10. 9. 1957, to 10. 14. 57, 19____, that I last saw the deceased alive on 10. 14. 1957, and that death occurred at 1 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. ADDRESS (Street, city or town, state): CHESTERTOWN, Md DATE SIGNED: 10.19.57

PHYSICIAN'S NAME (Type): A. T. KEEFE, JR. M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	Oct. 17	Woodlawn	Newburgh. N.Y.

23. FUNERAL DIRECTOR'S SIGNATURE: Evelyn L. Lane ADDRESS: Church Hill

24a. REC'D BY REGISTRAR DATE: OCT 16 1957

24b. REGISTRAR'S SIGNATURE: Clara Barnes

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10764

10764

CERTIFICATE OF DEATH

Reg. Dist. No. 201

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b: 3 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kent & Queen Anne's Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 Worton R.F.D.#1 Box 30
d. STREET ADDRESS: ---
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Daisy; Middle: ; Last: Howard

4. DATE OF DEATH: Month: October; Day: 22; Year: 1957

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 25, 1896

9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: Housework

11. BIRTHPLACE (State or foreign country): S. Carolina

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Harry Daniel

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.: 213-22-8846

17. INFORMANT: Arthur Howard Address: Worton R.F.D. Box 30

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Post operative shock — INTERVAL BETWEEN ONSET AND DEATH: 14 hrs.
576x
DUE TO (b): ~~Peritonitis~~ Intestinal obstruction — 24 hrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Peritonitis — 24 hrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Acute myocarditis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: ; o. m. p. m.: ; Month: ; Day: ; Year: 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct. 20, 1957, to Oct 22, 1957, that I last saw the deceased alive on Oct 22, 1957, and that death occurred at 7:05 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: A.C. Dick M.D. ADDRESS (Street, city or town, state): Chestertown, Md DATE SIGNED: 10-23-57

PHYSICIAN'S NAME (Type): A.C. Dick

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10/26/57

22c. NAME OF CEMETERY OR CREMATORY: Fountain Cemetery

22d. LOCATION (City, town, or county) (State): Worton Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Victor N. Kennedy ADDRESS: Still Pond, Md.

24a. REC'D BY REGISTRAR DATE: 10/24/57

24b. REGISTRAR'S SIGNATURE: E Kenard Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10765

10772

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Kent

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): (Fairlee) Chestertown — c. LENGTH OF STAY IN 1b: 8 Months

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Strong Nursing Home

d. STREET ADDRESS: High St.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Margaret — Middle: — Last: Jarman

4. DATE OF DEATH: Month: October — Day: 7 — Year: 19 57

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 31, 1893

9. AGE (In years last birthday): 64 yrs

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Kent Co. Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: G. Allen Jarman

14. MOTHER'S MAIDEN NAME: Mary ~~James~~ McWhorter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO: no

17. INFORMANT: Carey Jarman — Address: Baltimore Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 6 hours

DUE TO

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) generalized arteriosclerosis & hypertension — 2 years

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): chronic rheumatic heart disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year — Hour: a. m. / p. m — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from August, 1955, to October 7, 1957, that I last saw the deceased alive on October 7, 1957, and that death occurred at 3:20 p.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Florence Deringer Joyce M.D. — ADDRESS (Street, city or town, state): Worton, Maryland — DATE SIGNED: 10/7/57

PHYSICIAN'S NAME (Type): Florence Deringer Joyce m.d.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Oct. 9, 1957

22c. NAME OF CEMETERY OR CREMATORY: Chester Cem.

22d. LOCATION (City, town, or county) (State): Chestertown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J. Willis Wells — ADDRESS: Chestertown, Md.

24a. REC'D BY REGISTRAR — DATE: OCT 9 1957

24b. REGISTRAR'S SIGNATURE: Clara Barnes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10773 | 10766 | Reg. Dist. No. 208

M | I

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Chestertown
c. LENGTH OF STAY IN 1b: Transient
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Route 289 near Chestertown, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Queen Annes
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Church Hill - 17x
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) — First: HOWARD — Middle: BERNARD — Last: KENNEDY

4. DATE OF DEATH — Month: October — Day: 19 — Year: 1957

5. SEX: Male
6. COLOR OR RACE: Colored
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept 16, 1931
9. AGE (In years last birthday): 26 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: various
11. BIRTHPLACE (State or foreign country): Queen anne Co. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Theodore Kennedy
14. MOTHER'S MAIDEN NAME: Hilda Tilghman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 214-30-8293
17. INFORMANT: Barbara Kennedy — Address: Church Hill, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): accidental causes - probably drowning — INTERVAL BETWEEN ONSET AND DEATH: a few minutes
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Got out of car & went down into ditch where a ... no external signs of injury. Was lying face down in water

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) when found.
20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year: 10/19 1957
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway
20f. (City or town): Chestertown — (County): Kent — (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Robert W. Farr M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 10/19/57
EXAMINER'S NAME (Type): ROBERT W. FARR

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct. 23, 1957
22c. NAME OF CEMETERY OR CREMATORY: Church Hill Cem.
22d. LOCATION (City, town, or county) (State): Church Hill, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J. Willis Wells — ADDRESS: Chestertown, Md.
24a. REC'D BY REGISTRAR DATE: OCT 29 1957
24b. REGISTRAR'S SIGNATURE: Clara S Barnes

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12008

10774

CERTIFICATE OF DEATH

Reg. Dist. No. 2-3

1. PLACE OF DEATH
a. COUNTY: Kent
MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Kent

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rock Hall

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rock Hall

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

d. STREET ADDRESS

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Helen Middle: Maria Last: Kirby

4. DATE OF DEATH: Month: October Day: 27 Year: 1957

5. SEX: Fem

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: April 10-1878

9. AGE (In years last birthday): 79 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Address: Joseph Kirby--257 [illegible] St[illegible]--[illegible]ton, M[illegible]

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thrombosis Myocardial Infarct — INTERVAL BETWEEN ONSET AND DEATH: Unknown

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Hypertension

DUE TO

(c) Arteriosclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 1, 1957, to Oct 26, 1957, that I last saw the deceased alive on Oct 26, 1957, and that death occurred at M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Norbert C. Nitsch M.D. ADDRESS (Street, city or town, state): Rock Hall DATE SIGNED: Oct 29/57

PHYSICIAN'S NAME (Type): NORBERT C NITSCH ROCK HALL MD

22a. BURIAL, CREMATION, REMOVAL (Specify): I

22b. DATE THEREOF: Oct. 29

22c. NAME OF CEMETERY OR CREMATORY: Chester

22d. LOCATION (City, town, or county) (State): Chestertown, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Edgar L. Kane ADDRESS: Church Hill, Maryland

24a. REC'D BY REGISTRAR DATE: 10/29/57

24b. REGISTRAR'S SIGNATURE: Sylvia Burgess

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS 115 (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10765

CERTIFICATE OF DEATH

10767

Reg. Dist. No. 202

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b: 8 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kent & Queen Anne

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
STATE: Maryland — b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rock Hall
d STREET ADDRESS: Chesapeake Industrial Site
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: WILLIAM — Middle: E. — Last: LEARY

4. DATE OF DEATH: Month: Oct — Day: 24 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec 13, 1879

9. AGE (In years last birthday): 77 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant

10b. KIND OF BUSINESS OR INDUSTRY: Hardware

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Isaac Leary

14. MOTHER'S MAIDEN NAME: Virginia Martin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 212-12-5245

17. INFORMANT: Address: Wm L. Leary — Rock Hall, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Stroke — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Aortic insufficiency

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. — 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10/16, 1957, to 10-24, 1957, that I last saw the deceased alive on 10-24, 1957, and that death occurred at 3:32 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert W. Farr, M.D. — ADDRESS (Street, city or town, state): Chestertown, Md. — DATE SIGNED: 10/24/57

PHYSICIAN'S NAME (Type): ROBERT W. FARR

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: Oct. 26/57 — 22c. NAME OF CEMETERY OR CREMATORY: Wesley Chapel Cem. — 22d. LOCATION (City, town, or county) (State): Rock Hall - Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Marvin L. Williams — ADDRESS: Chestertown Md.

24a REC'D BY REGISTRAR DATE: Oct. 26-1957 — 24b. REGISTRAR'S SIGNATURE: Clara L. Barnes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10766

CERTIFICATE OF DEATH

10768 Reg. Dist. No. 202

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND

2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission)
a. STATE: Md b. COUNTY: Kent

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown

c. LENGTH OF STAY IN 1b: 2 yrs.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 27 Chestertown.

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

d. STREET ADDRESS: /

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First BRADY Middle A. Last MANLEY

4. DATE OF DEATH: Month Oct. Day 25 Year 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 11-1921

9. AGE (In years last birthday): 35 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plumber

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles Manley

14. MOTHER'S MAIDEN NAME: Enda Eubank

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Ruth Manley — Address: Chester. Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Chronic Myocardial Insuff.

INTERVAL BETWEEN ONSET AND DEATH: 18 mos

DUE TO

422.2

Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chr Asthma Paraplegia past 11 years

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March, 19 57 to Oct 24, 19 57 that I last saw the deceased alive on Oct 22, 19 57, and that death occurred at 8:15 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: H. H. Hamilton M.D. ADDRESS (Street, city or town, state): Millington Md DATE SIGNED: 10/25/57

PHYSICIAN'S NAME (Type): H. H. HAMILTON MILLINGTON Md.

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: Oct. 28

22c. NAME OF CEMETERY OR CREMATORY: Stonewall

22d. LOCATION (City, town, or county): Kingston (State): Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Edgar L. Lane ADDRESS: Church Hill Md

24a. REC'D BY REGISTRAR DATE: OCT 29 1957

24b. REGISTRAR'S SIGNATURE: Clara Barnes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

Item 18 Film 221 10-18-57 ams

10767

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10769

Reg. Dist. No. 502

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b: 10 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kent &Queen Annes

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rock Hall
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Margie; Middle: S; Last: McGinnis

4. DATE OF DEATH: Month: October; Day: 6; Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: January 13,1898

9. AGE (In years last birthday): 59 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS: Hours; Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Charles Kelley

14. MOTHER'S MAIDEN NAME: Grace Scott

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Hospital records & deceased
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Adenocarcinoma, Grade III, metastatic to liver

DUE TO: peritoneum and left pleural space

(Primary site unknown)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) DUE TO:

(c)

INTERVAL BETWEEN ONSET AND DEATH: Known for 1 month

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m.; Month; Day; Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ~~8/15~~ 8/15, 1957, to Oct 6, 1957, that I last saw the deceased alive on October 6, 1957, and that death occurred at 6:00A M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert W Farr M.D.

ADDRESS (Street, city or town, state): Chestertown, Md.

DATE SIGNED: Oct 6, 1957

PHYSICIAN'S NAME (Type): Robert W. Farr

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10-9

22c. NAME OF CEMETERY OR CREMATORY: Wesley

22d. LOCATION (City, town, or county) (State): Rock Hall Md

23a. FUNERAL DIRECTOR'S SIGNATURE: Edgar L. Lane

ADDRESS: Church Hill Md.

24c. RECD BY REGISTRAR DATE: OCT 10 1957

24b. REGISTRAR'S SIGNATURE: Clara Barnes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

EJ

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10770

CERTIFICATE OF DEATH

Reg. Dist. No. 702

1 PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
10769
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kent & Queen Annes Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
d. STREET ADDRESS: 506 Cannon Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Lee — Middle — Last Scott

4. DATE OF DEATH: Month October — Day 15 — Year 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: September 6 1900

9. AGE (In years last birthday): 57 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer & night watchman
10b. KIND OF BUSINESS OR INDUSTRY: Cannery
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William H. Scott

14. MOTHER'S MAIDEN NAME: Sally ~~Xxxxxx~~ Vickery

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO: 220-01-9649

17. INFORMANT — Address: Patient & hospital records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 13 days

DUE TO
(b): Intracranial Hemorrhage(stroke) — 6 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): X Diabetes mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from October 2, 1957, to October 15, 1957, that I last saw the deceased alive on October 15, 1957, and that death occurred at 3:15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert W. Farr, M.D.
ADDRESS (Street, city or town, state): Chestertown, Md.
DATE SIGNED: Oct.15,1957
NAME (Type): Robert W. Farr

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct. 17, 1957
22c. NAME OF CEMETERY OR CREMATORY: Chester Cemetery
22d. LOCATION (City, town, or county) (State): Chestertown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J. Willis Wells
ADDRESS: Chestertown, Md.

24a. REC'D BY REGISTRAR DATE: OCT 17 1957
24b. REGISTRAR'S SIGNATURE: Clara L. Barnes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10769 10771

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestretown, Md.
c. LENGTH OF STAY IN 1b: 10 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kent & Queen Annes

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rock Hall Md,
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Paul Middle L Last Stevens
4. DATE OF DEATH: Month October Day 6 Year 1957

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: September 21, 1920
9. AGE (In years last birthday): 37 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Driver
10b. KIND OF BUSINESS OR INDUSTRY: Trucking Compnay
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: K Jack Stevens
14. MOTHER'S MAIDEN NAME: Emma

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT Address: Hospital records & Mrs Paul Stevens, Rock Hall, Md,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Cirrhosis of liver with acute hepatic failure	
DUE TO	and/or hepatitis	3½ weeks
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO		
(c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)
October 6, 1957

21. I certify that I attended the deceased from September 26, 1957, to September, 19____, that I last saw the deceased alive on October 6, 1957, and that death occurred at 9:45P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert W Farr M.D.
ADDRESS (Street, city or town, state): Chestertown, Md.
DATE SIGNED: Oct 6, 1957

PHYSICIAN'S NAME (Type): Robert W. Farr

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-9
22c. NAME OF CEMETERY OR CREMATORY: Wesley Chapel
22d. LOCATION (City, town, or county): Rock Hall
(State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Edgar L. Daniel
ADDRESS: Church Hill Md.
24a. RECD BY REGISTRAR DATE: OCT 10 1957
24b. REGISTRAR'S SIGNATURE: Clara Barnes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10770 — 10772 — Reg. Dist. No. 202

1. PLACE OF DEATH
a. COUNTY: KENT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHESTERTOWN
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: KENT + QUEEN HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD. — b. COUNTY: KENT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X MILLINGTON
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First PATRICIA — Middle MAE — Last WATSON
4. DATE OF DEATH: Month OCT. — Day 13 — Year 1957

5. SEX: F. — 6. COLOR OR RACE: COLORED — 7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: NOV. 14, 1953 — 9. AGE (In years last birthday): 3 yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): BABY — 10b. KIND OF BUSINESS OR INDUSTRY: — — 11. BIRTHPLACE (State or foreign country): MD. — 12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: JAMES H. WATSON — 14. MOTHER'S MAIDEN NAME: SARAH JOHNSON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): — 16. SOCIAL SECURITY NO.: — 17. INFORMANT: SARAH JOHNSON — Address: MILLINGTON, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): UNKNOWN cause — INTERVAL BETWEEN ONSET AND DEATH:

41 *

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Probable Overwhelming Infection — 1 DAY

DUE TO (c): Pneumonia & Pleural Effusion -

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19 — 20d. INJURY OCCURRED: While at work ☐ Not while at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10/13, 1957, to 10/13, 1957, that I last saw the deceased alive on 10/13, 1957, and that death occurred at 9:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Thomas J. Solon, M.D. — ADDRESS (Street, city or town, state): Chestertown, Maryland — DATE SIGNED: 10/13/57

PHYSICIAN'S NAME (Type): THOMAS J. SOLON — CHESTERTOWN MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — 22b. DATE THEREOF: 10/16/57 — 22c. NAME OF CEMETERY OR CREMATORY: RILEY'S NECK CEM. — 22d. LOCATION (City, town, or county) (State): MILLINGTON KENT MD.

23. FUNERAL DIRECTOR'S SIGNATURE: Edward Hellers — ADDRESS: Millington Md. — 24a. REC'D BY REGISTRAR DATE: OCT 21 1957 — 24b. REGISTRAR'S SIGNATURE: Clara Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page [redacted] should be detached for use as the burial-transit permit. Then please remove carbon papers. Page [redacted] and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10771

10773

CERTIFICATE OF DEATH

Reg. Dist. No. 20 2

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland b. COUNTY: Kent

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown

c. LENGTH OF STAY IN 1b: life

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kent & Quee.. Anne Hospital

d. STREET ADDRESS: Kent St.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Pricie Middle Maslin Last Watson

4. DATE OF DEATH: Month Oct. Day 9, Year I957

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒X DIVORCED ☐

8. DATE OF BIRTH: 7/I6/I877

9. AGE (In years last birthday): 80 yrs

IF UNDER 1 YEAR: Months ____ Days ____ IF UNDER 24 HRS: Hours ____ Min ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY: Housewife

11. BIRTHPLACE (State or foreign country): Kent Co. Md.

12. CITIZEN OF WHAT COUNTRY? Usa

13. FATHER'S NAME: John Carvil Maslin

14. MOTHER'S MAIDEN NAME: Hannah Ball

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO: no

17. INFORMANT: Mrs. Rin[illegible]gold Strong Address: Chestertown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) [illegible]

420.1

DUE TO (b) Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 20 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 481x Influenza

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from [illegible], 19[illegible], to [illegible], 19[illegible], that I last saw the deceased alive on [illegible], 19[illegible], and that death occurred at [illegible] M, from the couses ond on the date stated above.

ADDRESS (Street, city or town, state) DATE SIGNED

ACTUAL SIGNATURE: A. C. Dick M.D.

PHYSICIAN'S NAME (Type): A. C. Dick Chestertown, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: IO/II/57

22c. NAME OF CEMETERY OR CREMATORY: Chester Cemetery

22d. LOCATION (City, town, or county) (State): Chestertown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J. Willis Wells ADDRESS: Chestertown, Md.

24a. REC'D BY REGISTRAR DATE: OCT 14 1957

24b. REGISTRAR'S SIGNATURE: Clare Barnes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely executed by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4) 1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10774

10775

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Worton
c. LENGTH OF STAY IN 1b: life
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Butlertown

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Worton
d. STREET ADDRESS: Butlertown
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒X

3. NAME OF DECEASED (Type or print): First Edward — Middle Whye — Last
4. DATE OF DEATH: Month October — Day 17 — Year 1957

5. SEX: M
6. COLOR OR RACE: C
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Dec. 25 1886
9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Kent Co. Md.
12 CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William Whye
14. MOTHER'S MAIDEN NAME: Mollie Dorsey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: ----
17. INFORMANT: Henry C. Whye — Address: Worton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Nephritis
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Heath Disease
DUE TO
(c):
INTERVAL BETWEEN ONSET AND DEATH: 4 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m., 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 20 1957 to Dec. 17, 1957, that I last saw the deceased alive on Oct 17, 1957, and that death occurred at 5 P. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: L. P. Atwell M.D. — ADDRESS (Street, city or town, state): Still Pond md. — DATE SIGNED:
PHYSICIAN'S NAME (Type): L. P. Atwell — Still Pond Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct. 20,57
22c. NAME OF CEMETERY OR CREMATORY: Butlertown Cemetery
22d LOCATION (City, town, or county) (State): Worton, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Marvin V. Williams — ADDRESS: Chestertown, Md.
24a. REC'D BY REGISTRAR DATE: Oct. 22-57
24b. REGISTRAR'S SIGNATURE: Clara L. Barnes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10776

10775

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Worton
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Muddy Branch Farm

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X/ Worton
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First Ralph — Middle P. — Last Williams Sr.

4. DATE OF DEATH: Month Oct. — Day 7 — Year 1957

5. SEX: M.

6. COLOR OR RACE: W.

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: May 7 1888

9. AGE (In years last birthday): 69 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming

10b. KIND OF BUSINESS OR INDUSTRY: farm

11. BIRTHPLACE (State or foreign country): Worton, Kent Co. Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George T. Williams

14. MOTHER'S MAIDEN NAME: Sara M tilda Porter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.: 220-34-9236

17. INFORMANT — Address: Sarah C. Williams, Worton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: few minutes

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): coronary insufficiency
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from November, 1956 to Oct. 7, 1957, that I last saw the deceased alive on Oct. 7, 1957, and that death occurred at 5:30P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: R Lee Macum M.D. — ADDRESS (Street, city or town, state): CHESTERTOWN, MD. — DATE SIGNED: Oct. 8, 1957

PHYSICIAN'S NAME (Type): Robert W. Farr, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Oct. 10, 57

22c. NAME OF CEMETERY OR CREMATORY: Still Pond Cem.

22d. LOCATION (City, town, or county) (State): Still Pond, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Marvin V. Williams — ADDRESS: Chestertown, Md.

24a. REC'D BY REGISTRAR: Oct. 10-1957

24b. REGISTRAR'S SIGNATURE: Clara L. Barnes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10777

CERTIFICATE OF DEATH

10776

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: KENT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): MILLINGTON
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD. — b. COUNTY: KENT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): MILLINGTON x2
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LEONARD — Middle — Last WILSON
4. DATE OF DEATH: Month OCT. — Day 20 — Year 1957
5. SEX: M.
6. COLOR OR RACE: W.
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: MARCH 4, 1875
9. AGE (In years last birthday): 82 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): BANKER
10b. KIND OF BUSINESS OR INDUSTRY: BANK
11. BIRTHPLACE (State or foreign country): MD.
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: EDWARD WILSON
14. MOTHER'S MAIDEN NAME: SARAH GREEN
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: MRS. LEONARD WILSON — Address: MILLINGTON, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cancer of the lung — INTERVAL BETWEEN ONSET AND DEATH: 6 Months.
163X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) — DUE TO
(c) —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Apr. 20, 1957 to Oct. 20, 1957, that I last saw the deceased alive on Oct. 19, 1957, and that death occurred at 9 A.M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Geza Koralewski M.D. — ADDRESS (Street, city or town, state): Millington, Md. — DATE SIGNED: 10-21-57

PHYSICIAN'S NAME (Type): GEZA KORALEWSKI

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 10/24/57
22c. NAME OF CEMETERY OR CREMATORY: MILLINGTON CEM.
22d. LOCATION (City, town, or county) (State): MILLINGTON, MD.

23. FUNERAL DIRECTOR'S SIGNATURE: Edward Fellows. — ADDRESS: Millington Md
24a. REC'D BY REGISTRAR — DATE: OCT 25 1957
24b. REGISTRAR'S SIGNATURE: Ella Mufford

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55